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NATIONAL HOSPITAL PROSPECTIVE PAYMENT EVALUATION

CASE STUDY SITE REPORT:

PORTLAND, OREGON

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PREFACE

This is one of ten site reports of case studies conducted between September and December, 1986, by staff members of Abt Associates, Inc. and Health Economics Research, Inc. under Contract No. 500-85-0015 to the Health Care Financing Administration (HCFA). The views expressed are our own and no endorsement by HCFA or the Department of Health and Human Services is intended or should be inferred. Each report is a summary of the facts and subjective comments from all participants at one of the ten sites.

This report characterizes the structures of parts of the health care industry (e.g., hospitals, nursing homes, home health agencies) in this site as they were perceived by members of the study team. Individual respondents and institutions are not mentioned by name, nor are they meant to be identifiable. We are interested in generalizing about the responses of the industry to the Medicare prospective payment system, not in pointing out any one type of response. We would like to raise the appropriate policy issues objectively and from all points of view. These issues can then be addressed in the statistical analyses of data on beneficiaries and providers, which in turn will be synthesized by HCFA staff into the Congressionally-mandated report about the impacts of the prospective payment system.

The ten site reports will not make up the report to Congress. The ten sites are not a scientifically representative sample of the nation's health care providers. Therefore, they are only illustrative of what is happening across the country. As such, they have already proven to be invaluable to the study staffs. The information and subjective opinions of the 500-600 respondents will be incorporated in the analyses of secondary data in five topic areas: hospital competition, alternative health plans, medical practice patterns, post-hospital care, and program operations. They are being used in developing hypotheses, exploring unexpected results and raising policy concerns.

We once again thank those many respondents who so generously gave us their time for the discussions that provided these insights. Special thanks are also due to the support staffs of Health Economics Research and Abt Associates for arranging the site visits and producing the reports, and to the secretaries of participating executives who coordinated the interviewing schedules in the field.

1.0 OVERVIEW OF PORTLAND, OREGON

The Willamette* River in northwestern Oregon drains the western slopes of the Cascade Mountains and the eastern side of the Coastal Range. The Willamette runs north to join the Columbia River and so has been a primary means of transporting timber, a major regional product. Oregon's three largest metropolitan areas (Eugene, Salem, and Portland) all lie along the river, within relatively easy reach of one another. The rest of the state is rural, the eastern two-thirds being especially remote and sparsely populated.

The city of Portland straddles the Willamette River just before it joins the Columbia. The importance of this position to the region's industry has contributed to the metropolitan area's growth. The natural beauty and mild climate of the area have also attracted immigrants from other states. The Portland metropolitan area includes four counties: Clackamas, Multnomah, Washington, and Yamhill. These four contained 42 percent of the total state population in 1980, half of which was in Multnomah county,the location of Portland itself.

The importance of Portland as one of the two largest metropolitan areas in the Northwest (along with Seattle-Tacoma) helps to explain its importance as a regional center for medical care. Portland's medical school admits people from all over the country. Portland's teaching hospitals have been the sites of major technological developments. Portland houses many of the state's special facilities such as a burn care unit, a center for neonatal intensive care, a trauma center, major centers for open heart surgery, dialysis, cancer, etc. One respondent summed it up by saying, "Eighty percent of Oregon's health care is given in Portland."

Despite this regional importance, the consensus is that Portland is overbedded and overdoctored. A recent area study reported these conclusions based on the numbers of beds and physicians per capita in the MSA and predicted that one large hospital would go out of business in the next few years. The report was mentioned, and agreed with, by virtually every person interviewed. The conclusions are in keeping with 1980 census data showing that the MSA had only 42 percent of the state population but 47 percent of the hospital beds, 52 percent of the nurses and 59 percent of the doctors. (One respondent stated that the excess of physicians drives the system.) It had only 39 percent of the nursing home beds in 1980, but respondents also feel that Portland is overbedded in that sector for its current needs.

This oversupply has created an extremely competitive environment. A 50 year history of alternative health plans contributes to the competition. In response, providers are aggressively forming networks to achieve complete vertical integration and manage patients' care and costs throughout an entire episode of care. This networking has considerably altered the structure of the post-hospital care industry over the past few years, and is expected to continue to do so. In addition to the aforementioned prediction of a hospital closing, there are predictions of

*Pronounced Wil-lam'-et.

closings in the home health and HMO industries. While it appears unlikely that there will be nursing home closures, entry of new providers is equally unlikely.

The networks in Portland revolve around hospitals, which in turn makes hospitals more involved in the linkages between acute care and pre- and post-hospital care. Even though there are predictions that the Portland hospitals will shrink, the hospitals visited in the case study are generally expanding. The expansion is in outpatient care and into new ventures and new areas of the industry. Some of these other areas (e.g., home health care) have likewise been expanding. For home health, however, expansion seems about at an end and some closures have indeed already occurred. It may be that once the networks have met their needs for home health services, non-aligned home health agencies will be squeezed out of the market. Given the oversupply, this is not generally viewed as a negative trend.

Hospitals are also more involved in the management of the links between themselves and post-hospital care providers. For example, discharge planning now receives far more emphasis, with more utilization review and coordination with the medical staff than may always have been the case in the past. Those interviewed in the aftercare industry generally perceive the current system as a vast improvement over that of a few years ago. On the other hand, some of those involved in patient management are now considering the possibility that reductions in lengths of stay have gone too far. Some contend that extending some hospital stays past the medical minimum may be cost effective by reducing costly readmissions.

The competitive pressures inherent in the oversupply of almost every medical service in Portland is undoubtedly a major influence on this area's health care industry. A second pressure is being exerted by the private insurors, both HMOs and more traditional commercial insurors, which are more actively reviewing medical utilization and calling providers directly about hospital admissions than in the past. In particular, alternative health plans (AHPs) are very important in the Portland market. AHPs have been an established presence in Portland's health care market for almost 50 years, and have shaped the relations that characterize the local environment. Other providers have historically competed with the AHPs for patients and with each other to be suppliers of special services to AHP enrollees. This has contributed to low lengths of stay in area hospitals and perhaps to a more ready reliance on utilization review. Now, many providers are further integrated into HMO ventures to compete even more directly with the AHPs for enrollees.

These two influences, competition due to oversupply and alternative health plans, form a backdrop to the advent of the prospective payment system (PPS). This third major force in the industry is significantly shaping the ways in which competition is taking place. Perhaps most importantly it provides a monitor, through the PRO. It also serves as a further impetus for local networks, reductions in lengths of hospital stays by 1 to 2 days overall, shifts from inpatient hospitalization to other settings (e.g., outpatient visits have doubled in recent years),

changing practice patterns (e.g., the use of 18-hour beds for many social admissions), and the restructuring of health care benefits and administrative practices.

All hosptial report significant reductions in both inpatinet admissions and days between 1982 and 1985, but these have stabilized in all but the smallest institution and have even increased in a few hospitals in 1986. Financially, the majority of hospital studied are doing quite well on total margins, but at least one has had some losing years over the last five and another has consistantly not been doing well but expects to reverse that. All executives interviewed feel that Medicare patients in general add more to revenues than to costs, attributing this to reduction in operating costs and to short lengths of stay. Other reasons for the financial health of many area hospitals maybe the fact that commericial insuers also pay a high proportion of charges and balance billing has been allowed. Virtually all financial officers are projecting losses on total margins by 1989, however, for a variety of reasons.

Efforts to lower costs per admission have concentrated on reducing lengths of stay and, consequently, the amount of labor required. Wage increases have been held down over the last three years but that is likely to change given the marked increase in nursing loads. Fixed costs are also being reduced through the coversions of space and beds to other uses. These conversions are targeted to more profitable services such as ambulatory surgeries which enhance hospitals' competitive status. There is evidence of price competition but it is not rampant. For inpatient charges, increases are reported to have been steady but low for the last three years. Higher charge institutions report that they are bringing their rates more into line with competitors but only slowly. Outpatient charges are reportedly more competitive but not uniformly so.

Respondents have many good things to say about PPS. More than one pointed out that there had been waste of resources in the past and that changes in admitting and discharge practices were overdue. Hospital-based respondents said that PPS had achieved its goals. For providers in managed care networks, PPS is viewed as a cumbersome transitional step to capitation.

Executives raise many problems with the way in which the system is administered, however. Perhaps the most frequent complaint is that the system is not prospective: Changes in the payment formula are frequent and not communicated in a timely way. Another complaint (from physicians as well as administrators) is that the system imposes many additional costs on them.

Discharge planners and respondents in both nursing homes and home health agencies generally agree that patients are being discharged from hospitals in an earlier stage of recovery and require more services than in the past. Further, the location of care is changing. Those who used to be the least severely ill in nursing homes are now among the most severely ill in the home setting. This leaves both HHAs and SNFs with increased overall caseload severity.

One area of concern was consistently raised by all respondents: patient education. Patients are poorly informed (or even misinformed)

about their insurance coverage, about their coverage under an HMO versus other alternative health plans and insurance programs, about the causes of the changes in practice patterns they perceive, and about the post-hospital care they must now give themselves. As competitive pressures cause providers to shrink or disappear, beneficiaries may get lost in the cracks of the system. This outcome is not being ascribed solely to PPS but rather to the huge degree of change and confusion in the industry to which PPS is contributing.

Portland is an area that is highly sophisticated to competition in health care. Even so, it demonstrates dramatic changes in the wake of the introduction of PPS. Thus, it is a particularly interesting example of the impact of PPS and potential developments in health care markets. "PPS is like a rock that has been dropped into a pond. The ripples keep spreading out." "Ninety percent of the changes have occurred but 90 percent of the effects are yet to come."

2.0 SCOPE OF INTERVIEWS

There are 26 hospitals in the Portland metropolitan area, but six are long term care facilities (one only as of summer, 1986) and one is a Veteran's Administration institution. Of the 19 non-Federal, short-term, acute care hospitals, seven participated in the area case study. Four of these are very large, with over 300 beds each, two had 100-200 beds, and one had fewer than 100 beds.

Sixty-six people were interviewed over a five day period. Table 1 presents the number of interviews by topic area and the positions of the respondents. Thirteen interviews focused on hospital competition; 10, on HMO activity; 17 were concerned primarily with utilization of resources and patient management in the hospitals; 19 were conducted in the post-hospital health care industry; while seven were with those involved in program operations.

To gain insights into the competitive environment of the Portland hospitals, six chief executive or operating officers were interviewed about their strategies and the relative positions of their hospitals. Information relating to price competition and financial standing was obtained in interviews with six chief financial officers plus one director of a hospital business office. In addition, four HMO directors were interviewed about competition in that sector of the industry. Six other HMO managers (e.g., people involved with quality assurance or marketing) were also interviewed to obtain more information about competitive strategies within that sector.

In the area of utilization and patient management, the site team spoke with five utilization reviewers, one DRG coordinator, five chiefs of staff, and six other physicians with admitting privileges at one or more of the hospitals visited by the site team. The physicians included a cardiologist, a cardiac surgeon, an internist, two specialists in renal dialysis and a rehabilitation specialist.

In the aftercare industry, team members interviewed eight hospital discharge planners, administrators of five nursing homes and five home health agencies, and an administrator of the visiting nurse association. Concerning program operations, interviews included the director of the Oregon Medical Peer Review Organization (OMPRO), the four directors of OMPRO's divisions for research, quality assurance, utilization review, and special projects, and two representatives of the fiscal intermediary.

TABLE 1

PORTLAND, OREGON SITE VISIT INTERVIEWS BY TOPIC AREA

	Hospital Competition	HMOs	Utilization and Patient Management	Aftercare Industry	Program Operations
CEOs	6				
CFOs/Business Manager	7				
HMO Directors		4			
Other HMO Managers		6			
U/R Coordinators			5		
DRG Coordinators			1		
Chiefs of Staff			5		
Physicians			6		
Discharge Planners				8	
Director of OMPRO					1
Other OMPRO Administrators					4
Fiscal Intermediary					2
Nursing Home Administrators				5	
Home Health Agency Administrators				5	
Visiting Nurse Association				1	
Total Number of Interviews	13	10	17	19	7

3.0 HOSPITAL MARKET STRUCTURE AND RESPONSES TO PPS

3.1 Competitive Market Structure

The Portland hospital industry is characterized by a fairly high degree of integration, both vertical and horizontal. Of 19 short-term, acute care hospitals in the MSA, 15 belong to one of four local networks of hospitals, which link smaller community hospitals with one or more specialty or tertiary hospitals for the referral of cases and the provision of special services. (These networks are not to be confused with regional or national purchasing groups for medical supplies. Virtually all hospitals also belong to such a purchasing group.) All of the local networks are non-profit and a number of the hospitals have religious affiliations. Two of them extend beyond the Portland area and at least one of the hospitals in a local network also has a separate connection with a national network, giving it potential access to larger markets for capital and management services. Three other hospitals (out of the 19) belong to regional or national hospital chains (but no local network), leaving only one of the area's hospitals formally unaffiliated with any other hospitals. This is a large tertiary hospital with 40 percent of its admissions from outside the Portland area.

Executives interviewed in this study all predict that integration will lead to an overall reduction in hospital beds, but the predictions differ with respect to 1) the number of local networks that will survive (3 or 4); 2) the eventual number of hospitals (some will disappear versus none will disappear but several will shrink greatly), and 3) the fate of the unaffiliated hospital.

These hospital networks are also integrated with physician groups (e.g., through starting an HMO), nursing homes and home health agencies. Some have also formed an alliance with hospitals in Vancover, Washington, for the sharing of extremely expensive medical equipment. This vertical integration throughout the hospital industry undoubtedly has repercussions throughout the other sectors of the local health industry as well.

For example, one executive points out that joining a larger system gives his hospital more access to the seven HMOs in the Portland area. This had not been a primary concern in the past when there had been only three plans. The largest alternative plan treated its members primarily in its own hospitals while the other two plans divided the remaining market share between them with one plan remaining in only one county of the MSA. The emphasis was traditionally on utilization review to control costs and keep the plans competitive. In the last few years, this has changed. (The changes are described fully in section 4.0.) The net effect has been a growth in the number of alternative plans, a growth in the numbers enrolled, and an increase in the degree of competition for those enrollees. It appears that this period of heightened competition will continue until the new, unaffiliated plans settle into more stable relationships with selected providers. All together, AHP activity makes up 3 to 7 percent of any one hospital's revenues but because this percentage is growing and uncertain, it is an important influence on hospitals' behavior.

The rest of the average hospital's revenue stream tends to be 35-40% commercial insurance, 40-50% Medicare, 5% Medicaid and 5% private pay. Bad debts and charity tend to be 2-5% but are 20% or more in three hospitals participating in the study. Two of these are tertiary hospitals and, because of their locations, emergency rooms, or funding, have much higher proportions of Medicaid patients (and bad debt) and a lower proportion of Medicare revenues.

Virtually all executives mention the state Medicaid program as a constraint. Oregon's Medicaid program has instituted a DRG-based, per-case hospital payment system. It also places a limit on the total days per year for which reimbursement is made. This program adopted the Federal DRG classification system and weights, but not the Federal rate. This means that Medicaid payments are less than corresponding Medicare payments. Medicaid payment rates are consistently reported as having been about 60% of charges in the past but are now 40% or less. This reduction is attributed, at least in part, to the poor performance of the state economy.

The Medicaid DRG-weights pose a special problem for pediatric and neonatal procedures, which are recognized as among the most problematic in the Federal system. A relatively large fraction of Medicaid cases are infants and children. Undervaluation of these DRGs exacerbates the financial pressures on hospitals with large Medicaid caseloads.

Medicaid poses particular problems for the two hospitals reported by everyone as having the largest proportions of indigent and Medicaid patients. In response, these hospitals are aggressive in helping their indigent patients to enroll for the benefits that are available. This assistance includes screening for eligibility; filling out the forms; and even seeing to it that the forms are filed at the Medicaid office.

Finally, there is a state planning commission, with which all hospitals must file their rates. Once filed, the rates cannot be changed for 30 days. No hospital executive reports this as a constraint. However, at least one respondent feels that the state is moving toward state-mandated rate regulation.

3.2 Hospital Performance

All hospitals report reductions of about 6-20% in inpatient admissions and days between 1982/83 and 1985. Both admissions and days have stabilized, however, at all but the smallest institution visited and in a few hospitals they even increased in 1986. Lengths of stay have fallen overall in the MSA. The decreases range from less than 10 percent to 20-25 percent. These are attributed to changes in practice patterns. In the past year, the lengths of stay also seem to have stabilized or increased, reflecting the changes in the mix of inpatients exemplified by the increase in the Medicare casemix index.

Of the six hospitals for which institutional-level financial information was obtained, four are currently doing quite well on total margins; one has been running small average surpluses with some losing years; and one has consistently not been doing well but expects to reverse that. All executives feel that Medicare patients in general add more to revenues than to costs. (Areas where PPS payments are perceived

to fall short are discussed below.) This is generally attributed to reductions in operating costs and to the fact that the area's shorter lengths of stay means that its costs were already at or below the national average at the inception of PPS. Respondents report that Medicare payments have been averaging 90 percent of charges or better under PPS, but are starting to decline. Another reason for the financial health of many area hospitals may be the fact that commercial insurers also pay a high proportion of charges and balance billing has been allowed.

The Portland hospitals generally break even on the trade-off of hospital-specific rates for national rates under PPS. That is, the medical education and disproportionate-share adjustments to the national rate make the Federal payment roughly equal to the hospital-specific rate. Because of this, large Portland hospitals generally do not benefit or lose by what is called "the Packwood deal" (which speeds the transition to fully-Federal rates for Oregon hospitals compared to the rest of the country) and small hospitals benefit by the move to fully Federal rates.

Virtually all financial officers are projecting losses on total margins by 1989, however, due to increasing costs, frozen Medicare payment rates and declining Medicaid rates. The increases in costs are seen as arising from inflation in supply prices, from increased depreciation and interest costs due to building and remodeling efforts, and to wage increases projected for the next year. There is a concern that if hospital charges rise too rapidly, it will precipitate state rate regulation. To keep from being squeezed between rising costs and constant prices, hospitals are active in searching for market advantages.

3.3 Changes in Hospitals Conduct Over Last Five Years

The term conduct denotes behavior and strategy on the part of firms in the market. The integration of the Portland health care industry, discussed in Section 3.1, is an example of the firms' conduct in the face of a changing environment. Other examples include changes that lower costs, changing prices, and forms of rivalry, such as advertising. Lowering costs will increase profits or lower losses even if market shares do not change. Price reductions and non-price rivalry are both ways in which firms compete for market share.

3.3.1 Lowering Costs

In the face of falling admissions, hospitals need to reduce resource use even more sharply to reduce actual costs per admission. Most of this cost reduction is being achieved by shortening the lengths of stay. This reduces the number of employees needed per patient and, consequently, the cost. In Portland, these reductions appear as layoffs of hospital staff from 1983 to 1986. The hospitals with positive operating margins generally report layoffs of 9-25 percent of their staffs. The range is due to differences in the expansion of outpatient and other departments. Where hospitals are expanding other departments,

they have often transferred support personnel to the other departments. The reductions were sometimes traumatic but one or more hospitals claim to have minimized this by relying on attrition without replacement.

One of the hospitals that is not faring well financially has targeted labor productivity as the major reason for its losses since 1983. Its productivity program can be expected to result in significant layoffs in the future. The other hospital with losses does not stress labor as its problem. It has reduced the number of FTEs over the last few years but sees loss of market share as a larger concern and is concentrating its efforts in that area.

Wage increases have been held down over the last three years but are mentioned by at least one Portland executive as something that will have to give this year because the nursing load has increase markedly. This increase is due in part to the earlier layoffs but more to the increase in the complexity of the cases now being admitted.

The second major area for cost containment is the reduction of fixed costs associated with empty beds. This is achieved primarily by converting the beds to another use. Other uses of the space are usually less resource intensive. For example, many of the hospitals have changed inpatient beds to outpatient beds. They have all instituted 12-, 18-, or 23-hour beds for cases that would have been social admissions, for observation of cases seen in the emergency room, or for outpatient procedures. This permits hospitals to continue their missions of social care to the indigent, the elderly, and those with no social support without incurring the costs of a routine admission or running the risk of a penalty for having a large proportion of medically unnecessary admissions. The conversion of inpatient beds is seen as decreasing revenues because even, with some denials, it is felt that the DRG-based reimbursements would be higher. However, the outpatient beds are perceived as desirable in re-educating the medical staff not to admit patients when it is medically unnecessary.

Other conversions of space include those to rehabilitation, psychiatric, or outpatient/ambulatory uses and the creation of less intensive "step-down" nursing units as an intermediate step between intensive and routine care. These changes in the use of space mean that occupancy rates are misleading indicators of available space. Portland hospitals generally have occupancy rates of 50-65 percent but the large hospitals actually report they have little available space on any given weekday. Other methods of containing costs in the Portland area include nursing productivity and flexible staffing systems; the use of formularies for hospital pharmacies; better preventive maintenance for equipment; the substitution, where possible, of less expensive devices in surgery patients; and the use of social service workers on the weekends to facilitate discharges.

3.3.2 Price Competition

There is evidence of price competition among Portland hospitals but it is not rampant. Last year the Portland Business Journal published average hospital rates for all hospitals. Hospitals with higher than

average costs per patient day report they have been bringing their rates more into line with their competitors by holding rate increases to 4-6 percent over the last three years. This means that their competitors' rates are rising faster, say 10-13 percent over the same three years. Other hospitals report steady, low rates of increase in inpatient charges.

Most hospital price competition is in terms of discounts from set charges. In this sense, there is active price competition for the 5-10 percent of the hospital market that AHPs pay to hospitals they don't own. (That is, the part of the AHP market that is supplied by their own hospitals is not competed for on the market at large.) There is some evidence that this price competition has brought some contracts to within a narrow dollar range across hospitals. However, one hospital executive pointed out that price competition is impossible when the buyer doesn't know what it has to buy. The inexperience of five of the AHPs means that they do not yet have statistics for their patient management needs and so cannot adequately specify the bundles of services for which they want prices from the hospitals. This is less the case with the oldest AHP, which has somewhat more information about its needs.

Outpatient prices, however, must be and are competitive. There is more out-of-pocket payment for these services, more uniformity about them, and, probably, an oversupply due to the expansion of most hospitals in this area. These pressures tend to keep them in line across most institutions.

3.3.3 Non-price Competition

Portland's hospitals compete in terms of price for a small, but important, part of their inpatient admissions. While AHP enrollments are growing and overall AHP use of area hospitals is increasing, some executives express the opinion that this is opportunistic on the part of the plans. "Right now it's cheaper [for AHPs] to buy the services you need rather than build the facilities. There's so much excess capacity that there are bargain prices. But if that changes, some plans will just modify their own facilities." In view of this flexibility, hospitals are trying to tie plans to them by more than price.

In addition, for the vast majority of hospital patients, the charges make little difference in their choices. Convenience, comfort, and the image of the hospital are more important considerations for patients covered by Medicare or commercial insurers. To attract these customers, hospitals compete in ways that do not explicitly involve prices. For example, semi-private rooms are converted to private, interior decoration is stressed, parking is accessible and free.

Portland and its suburbs are well spread-out along the Willamette River. The city experienced major growth some time in the past and, as a consequence, its hospitals are spread around the metropolitan area, not clumped together in a central location. Thus, patients can choose hospitals on the convenience of their locations. Further, while physicians have open admitting privileges at any hospital in the area, the dispersion of the hospitals means that most doctors admit primarily

to one hospital. With the three non-HMO health care networks, once patients have chosen primary care doctors, they are tied to a whole system of hospitals for future referrals.

The community hospitals can project the image that they are close to home but that they connect the patient to a larger, technologically more sophisticated hospital system. The tertiary hospitals can be seen as an integrated part of a larger system concerned with each patient's health, not as a separate institution which the patient chooses only when needed. In this environment, advertising either is image-oriented or promotes specific hospital programs such as smoking clinics, open heart surgery, cancer programs, etc. Advertising is not given major emphasis now. Executives state that budgets do not allow for major campaigns and that the market has been saturated. Hospitals that had major advertising budgets have reduced those efforts markedly and laid off personnel.

Convenience and comfort for the patients are receiving a lot of attention, however. All of the large hospitals are conducting major building and/or remodeling programs, especially for outpatient facilities. They stress convenient access for patients and doctors, and comfort and privacy for the patients. One hospital in particular is reported to have suffered admission declines because of its old physical plant and is trying to correct this situation for both inpatient and outpatient programs.

Because 80 percent of the medical care in Oregon is reportedly given in Portland, the area's hospitals have relied only on informal connections to hospitals in other parts of the state. This is changing as the tertiary hospitals seek to ensure a flow of patients. More formal programs with outlying hospitals are becoming established.

The other area for non-price competition is in attracting doctors. Here, Portland is following fairly traditional paths. Hospitals are trying to provide physicians with the most desirable facilities and best service. The emphasis is on outpatient programs, open heart surgery, and the like, not MRIs and lithotripters. While the latter are being purchased, more doctors can be attracted or kept happy for less money by better design of outpatient examining rooms, better surgical facilities, and so forth.

Most of the efforts at non-price competition involve further investment and building. They will contribute to increases in hospital costs through greater expenses for depreciation and interest. One or two hospitals are perceived by other executives as being vulnerable in this regard. The extent to which hospital investment can be funded by surpluses from the last few years will be a continuing advantage because it will help to keep prices down.

3.4 Reactions to PPS

Every non-physician interviewed in the hospitals had at least one positive comment to make about PPS. These ranged from fairly mild statements that there had been waste in the system in the past to:

"PPS is the only Federal program in the past 25 years that worked."

and

"To me Carolyn Davis is a hero (of course, it was just dumb luck)."

More reflectively, executives point out that it had been clear since 1980 or 1981 that business and government would not tolerate much more inflation of health care costs and that the industry had expected some change, although not the form it took. In Portland, hospital administrators also stress that PPS is just an addition to the changes they are facing.

Many of these comments may be due to the fact that most of these hospitals have benefited from the changes in the last few years, and know it. The Federal rates with adjustments have generally been at or above Portland hospitals' specific rates. It is also widely recognized that PPS has contributed in a major way to efforts to change practice patterns, control costs, and move patients to an appropriate outpatient setting. One executive surmises that for these reasons the site team would hear "better comments about PPS compared to a year and a half ago."

Hospital administrators do not perceive DRGs as a major concern in their strategies. While the major hospitals devote time to the analysis of winning and losing DRGs, all the executives interviewed take a tack that they will do little more than give more attention to outpatient programs and maybe de-emphasize some areas, such as orthopedics. As tertiary centers, they want the image that they handle virtually everything, and do it best.

Some executives feel that DRGs are a fad and will be replaced with some new approach. They hope that this will not happen too soon because of the costs the changes impose on their institutions. These costs were mentioned frequently. They include additional personnel for the business office, utilization review, and medical records departments, and additional discharge planners. Financial officers and physicians also mention the increased time spent trying to understand the changes in the regulations and dealing with increased paperwork. "There must be millions of dollars spent when any little wrinkle changes." Doctors are especially upset about this cost because they feel it takes time away from patient care.

Another frequently mentioned problem is patient education. This takes several forms. For hospital administrators, education means explaining to the public that Medicare benefits have been reduced and that the hospitals are not to blame for this. "Someone has to take the blame so the finger is pointing at doctors and hospitals."

For patient-care workers, patient education is actually a daily problem. Discharge planners and social workers must try to explain a vast and confusing system to patients who perceive only that they have lost "their rights." "Patients can't recover in hospital any more but

expect to be allowed to." One social worker pointed out that patients have never understood their benefits but now they are even more confused and afraid. One mentions an elderly patient who begged "Please don't put me away and forget about me."

Insurance advertisements are adding to the confusion by making misleading statements. One ad was cited that told patients they will have no additional charges (with the advertised insurance). This company's clients are especially irate about co-payments, uncovered days, etc., when the hospital bills for them.

Home health nurses also reportedly must do more health education for patients and their families. Here there are legal as well as medical concerns. What is a safe level of education? Who is liable if the family doesn't really understand the reasons for certain procedures and do not perform them adequately? This concern is raised by home health nurses in addition to the lack of reimbursement for education visits.

Many complaints have to do with the PPS update factors over the last three years. Financial administrators feel that "The government's got to recognize there's not much squeezing left to do. . . From here on, cost-cutting is more likely to mean lower quality." They consistently point to inflation rates for hospital supplies of all kinds of about 9 percent in the last year. They also express the belief that they were promised rewards for cutting waste but instead have been penalized for being competitive and efficient.

More specific complaints are aimed at PPS outlier payments (especially when there is respiratory failure) and at a perceived lack of recognition of the costs for cases involving multiple organ systems, especially renal dialysis. Each hospital regularly examines it outliers for patterns. To date, no significant patterns are found. All administrators are convinced this is a failure in their accounting systems. Executives can only compare reimbursements to charges and they recognize the shortcomings of such evidence. However, once cost accounting systems are installed, they expect to see a consistent bias of outlier payments below cost. They argue this is because the assumptions of the outlier concept are flawed: "These patients are <u>really</u> sick."

Additional problems are raised with respect to the incentives of payments for home and in-center renal dialysis. While these appear unrelated to PPS itself, they reflect the complexities hospitals face in finding the best setting for care. The reimbursement encourages home dialysis treatment but this is often more costly for the outpatient renal centers because of the turnover in specially trained home aides. Further, efforts to contain costs by reusing supplies may have gone as far as is safe.

A final area in which hospital personnel raise issues or concerns pertain to hospital-physician relationships. "Doctors in Portland are scared," and PPS (in the eyes of some) seems to pit hospitals against them in an adversarial situation. For example, hospitals have been "calling the bluff" of doctors who threaten to take their patients elsewhere. While some echo the sentiment that "private practice is a thing of the past" and doctors and hospitals must be part of a whole, no one likes to move into the new era fighting with their colleagues.

In addition to the pressures to monitor and question physicians, PPS has set up incentives for hospitals and home health agencies that are at odds with the economic incentives for MDs. Home health is perceived as competition to physician services in the hospital or office. Doctors are still rewarded for doing more for the patient even though the hospital will be penalized.

Despite these perceived flaws, administrators see many good effects spilling over from PPS to all hospital practices. Practitioners do not treat Medicare patients differently from non-Medicare admissions, therefore, all costs are more controlled. Medical education is changing as the hospitals institute regular Economic Grand Rounds. Quality of care is not perceived as having deteriorated yet and dumping is not a problem except perhaps for a few instances of ambulances taking derelicts to one specific hospital. The general sentiment is that the system is working fairly well (with a few exeptions) but that there is too much interference. "If they will just tell us where the system will be in 1988 or 1989, and leave us alone, we'll get there."

4.0 EFFECTS OF THE PPS ON ALTERNATIVE HEALTH PLANS

4.1 The Structure of the Local Industry

Alternative health plans (AHPs) have been an established presence in Portland's health care market for over 40 years and have played an active role in shaping the competitive relations and structures characterizing the local health care delivery environment. Historically, two health maintenance organizations (HMOs) including one plan claiming 20 percent of the Portland market, have visibly influenced the community. Over the past two years, following the dissolution of a third plan, competition in AHP markets has reached a fierce intensity, with the entry of five new HMOs and the establishment of a variety of new PPO and indemnity plans. Market competition now expands from the local core to regional, interstate and national bounds. This increase in numbers of plans and plan types has resulted in a confusion of multiple choices.

Interviews were conducted at four HMOs from the total of seven plans accounting for nearly 30 percent market penetration in the Portland area. The HMOs represent a variety of model types and administrative structures, which define and shape each organization's capitation incentives and risk arrangements, and these are reflected in the competitive strategies pursued by each plan. The very striking differences across plans only serve to underscore the diversity of options within fixed capitation plans and the potential for HMOs, especially in competitive markets, to adapt their structures to a broad range of health care delivery arrangements for consumer choice.

Individual plan characteristics have been determined to a great extent by historical process. The largest of the four plans is a "first generation" group model HMO in which the plan maintains contracts with its own closed panel physician group and also with hospitals that, in the Portland area, are owned by the plan. (In the neighboring Salem area, the HMO contracts with the only hospital in the community.) Under this arrangement, the HMO is able to maintain careful control over hospital and medical group services. With 20 percent market share, including Medicare and Medicaid enrollees, this group model has successfully maintained its hegemony among Portland area providers and insurers, without significant competitors in the HMO industry. The plan has long operated side by side with a large IPA model, that has contained its activities to a nearby county and has only recently attempted entry into the Portland market.

More recent arrivals have entered the local market within the past two years, following the dissolution of a third plan, a large IPA. This IPA had contracted with most of the remaining physicians and hospitals in the area, having been established to protect their patient markets by providing an alternative to the established group model. Local providers claim that the plan's failure, and subsequent closure by the commissioner of insurance, was due to a lack of effective incentives for cost containment, a failure to screen participating physicians adequately (including both providers who maintained cost efficient and inefficient practices), and a lack of adequate management information systems.

New plans, drawing from the IPA's experience, have more selectively targeted market segments and providers. They also appear to have

recognized Portland's market potential at approximately the same time. Explaining the proliferation of HMO activity since 1983, the CEO from one new plan explained, "After (the IPA) went under, we saw Portland as an area with good potential for HMO development: lots of empty hospital beds, an oversupply of physicians, and one major competitor. Obviously, a lot of other plans had the same idea."

That the timing of the IPA's failure occurred at about the same time as the implementation of the Prospective Payment System (PPS) may be coincidental; however, since that time, five new HMOs, a new PPO, and other plan options have entered the Portland market. One network HMO contracts on a risk-sharing basis with hospitals and physician group practices in the community; two IPAs contract with selected independent practitioners and their admitting hospitals. Like the previously mentioned group model, all of these HMOs are federally qualified and all, including the group, maintain some connection with regional or national corporations. Three of the HMOs enroll Medicare beneficiaries, including two risk-based plans; one enrolls Medicaid recipients. All maintain decidedly different contracting and service arrangements with providers and, although the plans offer a variety of services to members, benefit offerings are remarkably similar. Two of the four plans visited at the Portland site have recently initiated plans for other health insurance offerings, including PPOs and indemnity plans.

This diversity, while it may expand the range of choices for consumers, is capable of generating considerable confusion about what an HMO is and how providers and beneficiaries are expected to negotiate their way through each plan's system. Several respondents indicate a concern that, with so many plans, and with doubts that all could survive with time, some beneficiaries may "fall through the cracks." Lack of understanding differences in benefits, service coverage, and the "rules of participation" in different HMOs are cited as potential problems associated with the surge of new plan activity and the reorganization or closing of existing plans. Others express concern that such rapid change and reorganization in the health sector may eliminate the availability of services that may be required later should plans or other provided networks fold.

4.2 Competition

Portland has been considered a health care market experienced with competitive provider relations. Among alternative health plans, however, one HMO has remained dominant in the market, lacking significant competition until recently. The influx of new provider and insurance plans increases local competition for all plans. All three of the new, smaller HMOs have carefully targeted slightly different markets and differentiated plan offerings accordingly. Executives at each of the HMOs identify the established plan, as well as other HMOs in the area, as their competitors, but feel that they offer alternatives to these models. Plan strategies, however, do not focus on competition with other HMOs, but with traditional insurance options. Respondents identify their chief sources of competition as Blue Cross and other insurance plans, which retain a large share of the market. Executives at the established plan identify its competitors as Blue Cross, indemnity plans, and PPOs, as well as self-insured employers. Non-participating local physicians and group practices reportedly view the HMOs, in turn, as competing with them.

The lack of overt competition among plans perceived by HMOs in the Portland market is explained by three main factors: 1) the dominant position of the group plan relative to the newer, less established HMOs; 2) the diverse model types and plan strategies to target specific market segments; and 3) explicit attempts to differentiate benefit arrangements offered by each plan. One HMO manager states that their plan was developed specifically for members not attracted to group model service delivery -- and is oriented to members who prefer the flexibility of a physician group. An executive at another plan describes its appeal as being tied to local providers who prefer to enroll their fee-for-service patients in this plan and thus protect against patient enrollment in other HMOs offered in the workplace.

Plan executives generally believe that, at this point, the market could easily support several HMOs without apparent overlap, especially given the ready market of potential enrollees available following the collapse of Portland's large IPA model three years earlier. However, it is agreed that, as plans develop their markets further, not all will survive, some perhaps will merge with other HMOs or insurance plans. All plans stress the advantages of managed care in making available a comprehensive range of services with limited out-of-pocket expense as a major selling point over more conventional insurance plans. In this developed market many Portland consumers have been educated to expect these features.

The threat of national competition in local and regional markets is a growing concern to some local providers and payer groups, including Portland's established group plan. Having developed close ties with and a presence in the community over a period of many years, Portland's group model developed its reputation as a full service HMO committed to a comprehensive range of benefits, often exceeding acceptable norms in other locations. The threat of national competition is intensified by deregulation of the HMO industry and trends among many new plans to provide low option, limited benefits outside the requirements of federal qualification. These regulations have formed the backbone of many first generation plans, and they provide the basis for levels of benefits that local members have come to expect. Plan executives note that it has already been necessary to increase copayments initiated by the competition, as well as to forgo offering some non-essential community educational programs.

It has been suggested that the most effective competitive strategy to counteract the arrival of national HMOs might be to make the marketplace too competitive. Some of these plans, many of which are sponsored by 'giants' of the health care industry which have already entered markets in nearby Seattle, are expected to expand to the Portland area. They will add to existing competition by starting up a new plan or acquiring a plan already established in the area. Two small national HMOs have already set up operation in Portland. Experience from other regions indicates that the presence of these plans will dampen enrollment for other plans.

The lack of market entry by such plans until recently is attributed by one executive not to the PPS, but to Oregon's "lackluster economy". It is expected that as the economy improves, so will the appeal of the Portland marketplace. National proprietary HMOs, in particular, have been willing to accommodate the administrative demands (for new data, new

rating practices, simplified billing, etc.) of national employers. Their influence has placed additional pressure on other plans to comply equally. Contracts with national employers, this respondent adds, also make the groups' employees more accessible when the HMO expands to new areas.

The plans have also become a significant political force at both the state and national levels. In its last session, the Oregon Legislature voted to permit for-profit HMOs to do business in the state. These plans have likewise provided a significant influence affecting national legislation opposing, for example, the HMO Act as an overly regulatory constraint.

The result nationally has been the growth of large, national, vertically integrated health care organizations, highly motivated to compete in the marketplace. Portland's established group plan considers this an important factor for implementing competitive market strategy. Its strategy is simply to "keep them out," making it difficult for new HMOs to expand in Portland by continuing to grow, by keeping rate increases low, and by producing satisfied members -- thereby reducing the potential enrollment for new HMOs. "Our strength becomes an effective barrier to a national HMO with sights trained on our members."

4.3 PPS Effects on HMOs

4.3.1 Contracting for Hospital Services

The restructuring of hospital payment under the PPS has affected AHP competition, as well as performance, to varying degrees in accordance with the organization and structure of each plan's model type. PPS effects on AHPs are indirect outcomes of PPS effects on hospital markets. Hospitals in Portland are doing well under the system and in some respects this has made contracting with hospitals more difficult for the health plans. However, the relatively low occupancy rates, with more than 50 percent of available beds currently empty, and the oversupply of physicians in the area exerts an even more powerful appeal to hospital survival. This makes for a fertile environment for HMOs seeking contracts with hospitals. Physicians, concerned with the survival of their own practices, are partly accountable for the vigorous move observed in Portland away from hospital-based care and toward outpatient and office-based services.

All of the HMOs with the exception of the group plan, which contracts with its own hospitals on a global budget basis, negotiate per diem rates with hospitals. DRG reimbursement applies only to Medicare and Medicaid populations, which are a minority of HMO enrollees, and it is generally considered to be "too generous" and "inefficient" by the HMOs. In the opinion of one plan CEO, DRGs also present problems for HMO contracting with hospitals because it is harder to determine a plan's budget when actual diagnoses and plan group's characteristics are not known in advance.

The perception that hospitals are "hungry" has resulted in a situation in which the HMOs find it "easier to dicker" for rates. Two plans negotiate single, all-inclusive per diems, and one plan negotiates as many as six categories of rates (med-surg, neonatal, ICU, pediatrics, mental health and maternity) for members under age 65. This HMO has been

successful in negotiating separate all-inclusive per diem rates for seniors at five selected hospitals to within an extremely narrow dollar range.

Selecting hospitals on the basis of efficiency or the availability of special services, a strategy often employed by HMOs and PPOs to contain hospital benefit costs, so far occurs only on a limited basis. Variation in rates at local hospitals, which have provided favorable contracts to HMOs, has not yet posed problems for plans seeking competitive contracts. Some attribute this to the history of competitive forces in health care delivery in the area.

Currently, the newly formed network and IPA models establish contracts with those facilities where participating physicians or physician groups have admitting privileges. An executive at one plan announced that, because the HMO had recently entered the market, it contracted with 15 local hospitals -- all but the state-supported hospital downtown. It is expected that the plan may reduce the number of contracts within two years to five or six hospitals, however, with selection based on their experience with the plan.

One of the IPAs in the sample contracts only with hospitals in its sponsoring network, in order to maintain market share for affiliated providers. The network model, by contrast, contracts with 12 local hospitals for group members, and it maintains per diem contracts with only five hospitals where participating physician groups admit patients for its senior care plan. The manager for the Medicare component of this plan, which is administered as a separate program, suggests that the plan's enrollment potential for Medicare beneficiaries may be limited by physician group selection of and affiliation at one of Portland's large inner-city facilities, since older patients have expressed a dislike of the hospital's deteriorating physical plant and its location in a rough and undesirable area of town. This may prove significant to future enrollment efforts.

Local hospitals in this buyer's market are actively marketing selective service contracts to plans, with particular interest in the areas of specialty care and laboratory services. These practices influence not only services available through the HMO but, as Portland hospitals begin to consolidate their service capabilities within the local market, they also influence the patterns of availability and arrangements for care in the market area.

Contracting is not based solely on price, although cost is likely to be an important consideration. One HMO maintains its own hospitals, but contracts out radiation therapy to one large urban facility, and 30-40 percent of cardiac care to another hospital. The hospital assured the HMO of favorable rates well below the cost to the plan for providing the same services in its own hospitals, eliminating the need to duplicate services at the HMO -- ones that are likely to be costly and expensive technologies to acquire and maintain. This hospital, is also affiliated with one IPA and provides cardiac services to a second IPA in an attempt to compete with a second Portland hospital that also specializes in cardiac care.

The CEO at the one Portland IPA explains that his plan's decision to contract with this facility was based largely on the reputation of the hospital's cardiac specialist, a physician with considerable celebrity in the Northwest for his development of the artificial heart valve. This

physician, who maintains a loyal following with many patients devoted to his service, is also known for his personal marketing style. Hosting parties to celebrate his patients' recoveries, the physician captured local attention at a recent event to which 3,000 patients were invited. Offers from the competitor hospital to provide volume discounts for cardiac care to patients in the plan and its interstate affiliates were considered, but the IPA decided to maintain contracting with the physician's institute, considered an attraction at a competitive price.

There is little evidence of consortium arrangements by local plans to allow channelling from high-cost to low-cost facilities, even at the HMO that owns its own hospital facilities. It has been suggested that, because of excess bed capacity, all hospitals offer per diem rates to HMOs that are within so close a range that there is little need to channel patients across facilities. However, in the area of specialty services the group model HMO has made limited efforts, based on occupancy in the plan, to retain potentially expensive cases. Maternity cases, for example, are always kept within the plan (because their costs can vary considerably if not monitored) while cases requiring intensive care may be sent to other hospitals if the HMO's hospital is full because these costs are more predictable across providers.

4.3.2 Contracting With Physicians and Other Providers

The Portland HMOs maintain a variety of different contracting and risk arrangements with physicians and other providers included in the various plans. The group HMO contracts with its own large physician group, which retains MDs and other health care personnel as salaried staff. The network plan is the only HMO of the four in which physicians are fully capitated, at risk for specialty care and testing as well as for routine services. Capitation amounts are based on negotiated agreements with local group practices consisting of 25-100 MDs and are subject to both a floor (somewhat less than 3/4 of fee-for-service costs) and a ceiling (somewhat more than fee-for-service costs).

The two IPAs contract directly with individual practitioners, and they maintain small reserves to their capitated rates. At one HMO, participating MDs include only those physicians with admitting privileges at the affiliated hospitals that sponsor the plan. Physicians at this HMO are held at risk for all non-hospital services, with the exception of specialty referral. (A respondent at a competitor plan suggested that this plan's incentives encourage increased use of specialists, often at extra cost to patients.) At the other plan, a regionally based IPA which has recently entered the market, physicians are carefully monitored and are subject to a probationary period for ineffectual practice patterns. The HMO administrator indicates that the PPS has affected the contracting process with local physicians, because about 75 percent of the doctors in the area feel their incomes would be reduced under the PPS. In this HMO, approximately 500 physicians have been "invited" to join, based on their records for cost-efficient care in and out of hospitals. Also, stressing the importance of quality practice by plan physicians, a respondent claims, "Our HMO's physician roster reads like the 'Who's Who of Health Care' in this area," and this is an important marketing factor for the plan.

Most plans make limited use of nursing home services, given their patient populations, and when arrangements are necessary they are usually determined on a non-contractual basis at per diem rates. A 20-bed SNF unit is planned at one hospital that sponsors an HMO. The area's largest HMO uses as many as 91 facilities, and has not found special contracts necessary, either to assure availability or to maintain low rates. This plan does, however, sponsor its own home health care agency for plan members.

4.3.3 Effects on Cost Advantage

Most HMOs do not attribute major changes in their plan organization and strategy to the PPS. Because none of the plans use DRGs as a basis for reimbursement, direct PPS effects on Portland HMOs appear to be minimal. The PPS, however, has effected notable changes in the fee-for-service sector, in turn reducing the HMOs' major cost advantage, which is derived by managing inpatient hospital utilization (the most costly portion of the HMO benefit). Notably, the PPS has helped to create stiffer competition with respect to commercial plans. An executive at one plan notes that, prior to the PPS, the HMO had "a big cushion" relative to the fee-for-service sector. Since PPS, the state's average number of inpatient days per thousand has dropped from 800 to 500, reducing averages even for non-DRG payers. The HMO average, which had initially been at 500 days per thousand, has dropped to 400 days, and there is little left to squeeze. "From an insurance standpoint," this has created a very competitive situation. The Blues budgeted for 800 days but, with 500 days now the norm, they have been able to amass great reserves."

4.3.4 Administration and Operations

The most obvious impacts of the PPS on HMO performance have occurred in the areas of plan administration and operation. These changes have occurred primarily in areas related to hospital use and documentation necessary for utilization review and quality assurance monitoring by the Oregon PRO. One plan executive states that the most significant impact of the PPS has been to generate among hospitals an awareness of the cost of health care delivery: "The government started the process, private insurers finished the job -- we hit (hospitals) at the bottom line." Hospitals, by diverting attention to DRGs and new reporting requirements have been "too busy dealing with Medicare," allowing other third-party payers to focus their efforts on non-hospital services and to their own inpatient hospital utilization. This IPA, most recently, has focused its efforts on ratcheting down, by "nickel and diming" non-hospital utilization, which accounts for 60 percent of indemnity plan benefits.

Most of the HMOs do not use DRGs to monitor beneficiary utilization, largely because DRGs in Oregon hospitals apply only to Medicare and Medicaid patients and thus have limited utility for most group members. Plan managers view DRGs as inefficient, posing difficulties for hospital service budgeting, because case mix is not controlled. The CEO at the hospital owned by one plan admits that, so inconsequential is the PPS to the hospital that he does not know, or

consider particularly important, the hospital's DRG payment rates. The plan, which serves both cost and risk Medicare members, finds the PPS burdensome and a contradiction to the incentives of fixed capitation. There are no distinctions made by the plan to differentiate the treatment of cost and risk beneficiaries, and PPS reimbursement applies only to a few cost-based members in the plan who account for fewer than half of the plan's Medicare patients. Because DRGs are used only for outside Medicare billing, the plan is also subject to PPS incentives that restrict the transfer of patients from outside hospitals to their own facilities except under conditions of medical necessity. HMO administrators at three of the four plans view DRGs as an interim step toward capitation for both the public and private sectors, and thus they do not accord the PPS system itself much importance.

4.3.5 Utilization Review

There is one area of unambiguous PPS impact for HMO performance: utilization review (UR) and patient record documentation. All plans note an increase in UR activity since PPS and a notable increase in patient documen- tation. The Medical Director at one HMO explains, "On the one hand, it's a pain; on the other, I suppose it keeps (us) docs on our toes and is ultimately good for the system." Another respondent states that the PPS has, indeed, affected local practice patterns -- especially in the area of hospitalization -- although, in the end, everyone has benefited.

Portland's experience with managed health plans and financial incentives to reduce health care costs through efficiencies in purchasing and pricing strategies has created the perception of having squeezed the health care system to greater efficiency. Plans are now focusing to a much greater extent on utilization review and patient care management, both in hospital and across-provider settings.

PPS effects on HMO utilization review have been indirect and consist primarily of even more stringent plan monitoring and review, to meet rather dramatic practice changes, including reductions in lengths of stay and shifts to outpatient use in the fee-for-service sector. Review by the PRO occurs for all hospitalized Medicare HMO patients enrolled in senior plans. However, the plans themselves have also affected local practice patterns, providing standards of efficiency endorsed even by the PRO. Changes to out-patient settings for cataract (lens) surgery, in fact, were initiated by one HMO and then endorsed as a model for other providers by the Oregon PRO.

Concurrent review, which is said by some to be among the most effective, if costly, form of review, is used by both IPAs in the Portland study, although on a somewhat different basis. In one hospital-sponsored plan, UR is performed by staff at the affiliated hospitals, which are at total risk under per diem contract arrangements. At the network plan, utilization review is also conducted by the hospital, although the plan's medical director oversees these activities.

Utilization review is the primary tool for cost containment at one IPA through its "Certified Hospital Admission Program" (CHAP), which applies "the same methodical controls and information systems that American businesses have used for years." CHAP involves concurrent review of medical records and prior approval for all admissions by the plan. Physicians are monitored closely, by profiles of admitting and

practice patterns as well as financial cost profiles, which are reviewed by the plan's Medical Director. Those physicians with unacceptable profiles are subject to a six-month probation period; the HMO may also elect to charge a physician's withholding account, established for capitation payment.

Two plans actively monitor utilization outside the hospital setting, and a third is investigating a quality assurance plan for outpatient use. Monitoring care across providers is facilitated by the maintenance of one chart for each patient and automated patient records, which are accessible to all practitioners in a plan. Recently, one HMO has started quality assurance activities in contracting hospitals. Administrators at this HMO also plan to develop protocols across providers and settings of care, rather than focusing on individual physician practices. This approach represents a significant move away from using the physician as patient manager and toward management by the physician group. The HMO, which now coordinates generic, non-focused UR through the hospital, is examining criteria for treatment and screens that can be applied to the 20 most frequent hospitalizations.

4.3.6 Benefit Structure

With competition increasing in insurance markets, HMOs and other insurance plans are altering forms of benefit and health care delivery from established informal standards in the community. The results are most apparent in two areas: 1) increasing copayments and deductibles in HMOs, PPOs, and indemnity fee-for-service options; and 2) changes in benefit offerings and pressures to offer competitive service options.

Strategies to segment the market for health insurance have redefined established levels of care, in part due to the influx of regional and national plans. Executives at Portland's established group model HMO state that, in response to competitive pressures, their plan has introduced copayments for many services, and has refrained from expanding some of its community prevention and outreach programs. The comprehensive coverage available through this HMO, including a 365-day hospital benefit for both Medicare and group members, has imposed pressure on other payers to provide similar coverage. High option standards of benefits, particularly for Medicare beneficiaries, together with increasing copayments necessary to maintain these benefits in an increasingly competitive market, are developing both greater diversity--and an increasing convergence--of benefit availability and community standards.

4.3.7 Medicare Enrollment and Contracting

Enrollment of Medicare beneficiaries in HMOs has been growing in the Portland area. Several new plans have developed senior programs, and Portland's established group model has increased its Medicare enrollment since 1980. Only one of the four plans in the site visit does not include Medicare members.

PPS does not appear to have affected Medicare enrollment directly. Plan decisions to contract with Medicare appear to be influenced by several factors: 1) the perceived adequacy of the Medicare rate, based on the average adjusted per capita cost (AAPCC) for beneficiaries served

in the fee- for-service sector; 2) the perceived need to enroll Medicare beneficiaries to retain market share; and 3) changes in the terms and cost- and risk-based contracting enacted by HCFA for HMOs in 1985.

Recent changes to risk-based contracts for Medicare patients have posed some inconsistency in the administration of benefits for Medicare beneficiaries at one plan, because HCFA has not allowed conversion of cost-based members, who make up less than half of the plan's senior members, to risk contracts except on a phase-in basis. Current regulations allow conversion of one cost-based member for every two new risk enrollees. The inability to convert Medicare membership is perceived as a competitive disadvantage which will take considerable time, given the relatively high percentage of beneficiaries currently enrolled in the plan. PPS, which bears no relevance to plan incentives, poses additional burdens for the continued enrollment of Medicare beneficiaries.

Two plans administer the senior plan as a separate business. An IPA respondent reports that they have "not been burned yet," but they "remain chary." Plan administrators intend to continue senior enrollment, however, due to a commitment by the hospital sponsor to serve the elderly and the poor, and due to the demographic characteristics of the hospital's market area.

Another local plan, which is part of a national chain, also operates its senior option as a separate program. The plan was started largely because local physician groups were losing market share to an established plan. Physicians as well as hospitals are at complete risk under the senior plan capitation arrangement. This plan, like all of Portland's senior plans, offers a 365-day hospital benefit -- a community standard adopted "solely in response to competition in the area." Any additions to the benefit, required by HCFA if plans generate profits in the enrollment of Medicare beneficiaries, have been made as non-structural benefit changes, outside the supplemental benefit offerings. This same approach was noted by the larger HMO, which also has opted to expand outside the supplemental insurance area. HMO spokespersons have usually avoided more structural benefit changes so as not to be committed to a "Cadillac plan" in the event that their Medicare experience, or government contracting rules, change -- committing the plan to an established pattern of care that has already been accepted by consumers.

4.4 AAPCC and Availability of HMO Options to Beneficiaries

Several HMO executives commented on the AAPCC and plan willingness to enroll beneficiaries. At one plan, a respondent thinks that the AAPCC in the Portland area has increased by approximately 14 percent, although no one seems to understand why. (Perhaps this is due, in part, to the time lags in applying AAPCC rates, averaged over a five-year period.)

One executive identifies problems with the county-specific service areas as the basis for AAPCC calculations. Since plans often service several counties, HMOs are encouraged to select only certain counties for their marketing efforts, and not others. At another HMO, the plan director also notes that these large disparities across counties encourage selective marketing: "There's great variation in the AAPCC within a plan's market area, but the same price must be charged."

The Salem area, for example, is served by only one plan, an established HMO that has considerable experience with Medicare enrollment and a sizable non-Medicare population to spread the risk of potentially adverse enrollment. Other plans continue to question how the plan can be successful in this area, since there is only one hospital located in the community, which this plan, and other potential plans, might engage in contracts. Most plans in the Portland area do not view the AAPCC in Salem as adequate for enrollment. In addition, there are few physicians per capita in the area, unlike Portland, further reducing the expected success of HMO models.

Only one plan strongly opposes enrollment of Medicare populations. This opposition is rooted in concern that "the government is changing too fast, especially under COBRA, which makes Medicare contracting 'too tricky,' with too frequent changes, the 95% AAPCC rule, and the 99-cent dollar." This plan's administrator is quick to point out that the plan is "unwilling to supplement Social Security by private insurance."

4.5 Beneficiary Perceptions of the PPS and HMOs

Several respondents indicate concern that inadequate attention has been directed to developing beneficiary awareness and understanding of health benefit coverage under Medicare. HMO executives are critical of government's perceived failure to provide seniors with appropriate information about recent program changes. One senior plan executive reports that Medicare beneficiaries are "scared" of the DRG system and have heard "stories of how they might be affected." Beneficiaries are uncertain about how the new system will affect their access to care and its quality. They also appear to be confused about the increasing co-payments and deductibles required for traditional Medicare benefits. These issues have become prominent in HMO marketing meetings where, reportedly, "You can hear their panic and fear."

HMOs have presumably had a much easier time with enrollment because of the uncertainty about PPS and insecurity experienced by many seniors in the Medicare program. Seniors are apparently more willing to accept the HMO option, avoiding the complicated paperwork and confusion over benefits under Medicare's traditional plan. A survey at one HMO, in fact, showed that two out of three senior plan members were new to the medical groups they have signed with -- indicating a willingness by the elderly to change providers, contrary to popular belief, and to accept alternative delivery systems.

5.0 MEDICAL PRACTICE PATTERNS UNDER PPS

5.1 Utilization Review

To understand the Portland health care system, it is important to recognize that residents of Portland have supported non-traditional forms of medical provider organizations, notably prepaid and other forms of group health plans, since the 1930s and 1940s. A key to the success of any prepaid health plan is effective utilization control, especially control of the use of hospital inpatient resources. Out of Portland's flourishing HMO/IPA activity, local providers have evolved a particular brand of competition for relatively scarce patient demand.

To attract and hold patients belonging to prepaid and group practice plans, some local hospital and physicians have competed by controlling costs (i.e., utilization of services) per admission. Consequently, a tradition of hospital utilization control preceded Medicare's PPS. Almost all of the Portland hospitals in which interviews were conducted had lengths of stay considerably below the national average both before and after the start of PPS. Credit for the historically shorter lengths of stay is also given to the PSRO operating prior to PPS. Its successor, the Oregon Medical Peer Review Organization (OMPRO), is also recognized as a major factor by both physicians and hospital staff.

OMPRO uses an algorithm developed by Interqual to flag potentially inappropriate Medicare admissions and to establish length of stay guidelines. Hospitals' emphasis on avoiding inappropriate inpatient admissions is one of the most frequently mentioned outcomes of the PPS. To minimize risk of OMPRO denial of admissions, many Portland hospitals use the same Interqual criteria as part of their internal UR processes. Most hospitals apply those criteria to <u>all</u> admissions, not just Medicare. So to the extent the PPS tightened hospitals' admissions criteria, it did so for Medicare and other classes of patients as well.

Admissions flagged as potentially inappropriate are quickly brought to the attention of the attending physician. In all hospitals, there is a formal process for scrutinizing flagged cases; these generally involve passing case information to an internal advisory panel of physicians for review. At some point in the process, the admitting physician is given the opportunity to offer additional evidence or explanation for the admission decision.

In practice, only a small number of cases are subject to detailed review by physician advisory committees. Rough estimates are that only 5 to 10 percent of all admissions are flagged as potentially inappropriate, and only about 1 percent ultimately are referred to hospitals' internal advisory boards. Furthermore, the penalties for inappropriate admission are not particularly severe; frequently, there is only a letter of reprimand from the hospital's chief of staff. This is not to imply the UR systems are weak or ineffective. Rather, they work because of a sentinel effect (i.e., the influence of peer oversight on the behavior of professionals) and not because of the threat of sanctions.

Anecdotal evidence suggests that physicians have adapted well to these UR systems. At least, the case study did not uncover consistent complaints or hostility toward them. Again, tradition might explain this. Physicians who find reviews to be grossly intolerable would not have stayed in practice in Portland owing to the strong tradition of review.

Among the scattered complaints one was repeated often enough to warrant special mention. It concerns the ex-post nature of OMPRO reviews, a process based on information not always available to hospitals and physicians at the time of a decision to admit. The problem is that physicians' preliminary diagnoses are not always correct--but are consistent with the symptomatic evidence available at the time. In some cases, subsequent observation and monitoring gives additional evidence leading to a revised diagnosis that does not justify hospital admission. Some health care providers are critical of retroactive admission disapproval by OMPRO under these circumstances.

Length of stay is the other important parameter monitored by utilization review systems. In Portland hospitals, UR staff follow the progress of nearly all admitted patients as part of concurrent review processes. If a patient remains hospitalized past the time when medical evidence (applied to a set of pre-established discharge criteria) suggests the patient no longer requires it, the case is referred to a peer review committee. The procedures for reviewing lengths of stay are essentially the same as those used by committees when reviewing admissions.

Under PPS, hospitals have strong incentives to strictly monitor Medicare LOS, an action that physicians might find particularly intrusive or distressing. However, there is little evidence that is so in Portland. Rather, the concensus among interviewees is that physicians have adapted well to the tighter reviews post-PPS. Nor is there any consistent complaining by physicians that shorter stays have compromised the quality of medical care that patients receive. Evidently, length of stay reduction was achieved in two ways: increased efficiency in scheduling, testing, and treatment; and reduction in the duration of purely recuperative or accommodative periods at the end of a hospital stay.

Physicians' acquiescence to pressures to reduce hospital stays post-PPS is the consequence of two factors. One is the often-mentioned tradition in Portland that holds utilization review to be a legitimate activity in hospitals. The second is the recognition by physicians that the medical and economic integrity of their own practices depends on the economic viability of their affiliated hospitals.

Several interviewees mention that HCFA might not appreciate Portland's success at controlling inpatient utilization. In particular, they fear HCFA might pressure OMPRO to wring out even more reductions in Portland's average length of stay even though it is reportedly already among the lowest in the country. They argue that OMPRO is likely to realize ever smaller returns to effort at the margin--and suggest that further reductions in hospital utilization might begin to compromise quality of care.

5.2 Effects on the Mix of Patients in Different Settings

PPS-induced tightening of inpatient admission rules has altered the pattern of inpatient admissions to Portland hospitals for all patients. An important change is the acceleration of a trend underway prior to PPS: the shift away from inpatient toward outpatient care, especially for routine surgery.

Innovation in medical technology, anesthesia, and techniques are among the primary factors behind the shift toward outpatient medical care. So are recent changes in public opinion regarding its acceptability; changes partly attributable to efforts by employers and their affiliated insurers to promote faster and less costly medical care.

PPS gives further impetus to this trend. The vehicle for that impetus is the contract between Medicare and Oregon's OMPRO. This contract required the PRO to establish and meet targets for reducing unnecessary Medicare inpatient admissions, and it was natural for it to promote ambulatory surgery and other outpatient services in that context. In particular, OMPRO distributed a list of targeted procedures for which inpatient admission require pre-authorization. That is, OMPRO distributed a list of services to be performed on an outpatient basis unless special circumstances justify an inpatient admission.

Logically, promotion of particular ambulatory surgical services presumes a local hospital industry capable of delivering them; a presumption that might be more valid in some areas than in others. The inference to be drawn from the Portland visit is that PPS was not the primary factor behind hospitals' adoption of the relevant technologies, but it did shift outward the local market demand curve for outpatient care. That notwithstanding, the PPS has affected some hospitals' plans for future capital expansion. Program incentives favor investment in ambulatory care facilities, and some local hospitals have responded accordingly.

A more immediate consequence of the emphasis on outpatient care perceived by some physicians and hospital staff is a change in the inpatient case mix. There is not unanimous agreement on this point; but in general the more highly specialized physicians are of the opinion that inpatient cases are noticeably more sickly and complex, post-PPS. The rationale offered is that patients who are the best medical risks (especially the best surgical risks) are shunted to outpatient units. The higher risk, more complex cases remain to be treated on an inpatient basis. Another observation is that some outpatient alternatives to complex surgery (e.g., angioplasty as an alternative to bypass surgery) might ultimately lead to complications and more risky surgery than initially might have been required.

5.3 Other PPS Effects on Ambulatory Care

Portland area hospitals have responded to PPS rules governing appropriate admissions in yet another way. Several have expanded the menu of ambulatory care services offered to include time-limited emergency bed programs. Under these programs, hospitals offer patients

short-term (less than 24 hours) placement in designated ER beds for extended observation, diagnosis, or other purposes. The programs fill a need perceived by the hospital: care for patients not sick enough to justify an admission yet requiring services beyond the acute care traditionally provided in emergency departments. Hospital staff admit that at least some admissions to these time-limited ER programs are for social reasons. That is, admittees are medically stable but not fully capable of self-care and lacking spouse, family, or other source of assistance at home.

The sentiment among providers in the Portland area is that the PPS has made it difficult for them to provide these kinds of social services on an inpatient basis. At the same time, they perceive pressure from the community to continue doing so. The time-limited ER bed programs are one solution; Medicare still pays costs for outpatient service, and hospitals are able to provide some socially motivated care without running afoul of PPS-OMPRO admission rules.

5.4 PPS Effects on Discharges

A consensus among those interviewed is that an important effect of the PPS is earlier discharge of patients. In effect, this confirms the hypothesis that Medicare patients are discharged sicker-quicker under the PPS in contrast to before it. An important corollary finding is that sicker-quicker discharge is not necessarily synonymous with poorer quality care in the hospital. Many administrators and physicians offer the opinion that medical care is not being compromised by the emphasis on earlier discharge; necessary services are being provided, and patients are not being discharged before they are medically stable.

However, the heightened emphasis on shorter inpatient stays has disrupted traditional approaches to case management, taking into consideration the entire episode of care including post-hospital services. No longer is an inpatient stay automatically extended to accommodate the wishes of medically stable patients for assistance during their recuperation. Patients and their families perceive this shift in policy as a break with tradition; one that places unanticipated and undue burdens on them. Now, families are reportedly chafing under new responsibilities to provide nursing and custodial care for recuperating Medicare patients; responsibilities they had come to believe were the hospital's. Stricter interpretation of rules governing Home Health Agency (HHA) benefits by the local Medicare intermediary exacerbates this problem. Just as the PPS (with its emphasis on early discharge) is increasing patients' and families' need for auxiliary support services, Medicare has restricted the availability of one important class--visiting nurses funded by the HHA program.

Many providers compain that the health care industry is unfairly cast as the villain in this situation. In their view, HCFA and OMPRO have established incentives and policies aimed at reducing inpatient length of stay--and providers have responded accordingly. What upsets them is the lack of public awareness that tightening inpatient utilization is a goal of the Medicare program. Providers are irritated that HCFA is not publicly acknowledging that goal. A case in point is

the letter HCFA distributes among Medicare patients advising them that decisions on length of stay are the prerogatives of physicians and hospitals. The letter advises patients to challenge providers if they believe they are being discharged prematurely. Hospital executives, discharge planners, and physicians believe HCFA is being disingenuous by not acknowledging in the letter that a goal of the PPS is to reduce Medicare hospital costs through a tightening of utilization--including elimination of unnecessarily long patient stays.

6.0 THE POST-HOSPITAL HEALTHCARE INDUSTRY UNDER PPS

Post-hospital care (PHC) providers in the Portland area generally agree that the patients they admit are in an earlier stage of recovery and require more services than in the past. Most PHC providers have added and/or retrained staff to meet increased needs, particularly in the area of high-tech care. There is a shortage of skilled nursing staff in the Portland area; several PHC providers have increased salaries lately to try to attract more highly skilled nurses, without much success.

Caseload severity seems to be distributed differently between nursing homes and HHAs, as a result of earlier discharges. As one nursing home describes the situation, their Medicare caseload of cancers and strokes is unchanged, but the fractured hip patients now go directly home from the hospital rather than spending a few weeks in an SNF bed. While the LOS for a given type of patient has therefore decreased slightly, the general caseload severity has gone up. HHAs in turn are treating patients requiring many more services now than was true in the past. Those who used to be the least severely ill patients in nursing homes, are now among the most severely ill patients in the home setting. This leaves both HHAs and SNFs with increased overall caseload severity.

One hospital-based HHA provided data indicating that although total visits have risen and number of patients admitted has risen, visits per patient have declined since 1980. The greatest decline was between 1983-84 and 1984-85. This respondent also states that patients require more high-tech services than in the past, although these two findings seem somewhat contradictory.

Several respondents feel that they are seeing more patients dying sooner after SNF admission than was true in the past. Some report there are more total deaths, others that death occurs more quickly than had been the pattern. One nursing home in an outlying area reports that Medicare deaths rose from 63 in 1984 to 90 in 1985. This nursing home conducted a study to objectively measure health status of patients at admission to the nursing home and found greater acuity of illness in the post-PPS period.

A problem HHAs consistently describe involves patient education. Because patients spend fewer days in the hospital, most educational activity now must occur in the PHC setting. Educational services are generally not reimbursed by the FI, so although the HHA nurses clearly must educate patients (for example those with permanent colostomies), they are not reimbursed for this service. This is one example where earlier discharge has an impact that goes beyond strictly defined medical care, but which cannot be ignored by the PHC providers.

Earlier discharge from hospital requires better discharge planning. PHC providers generally agree that discharge planning, especially with respect to placement, has improved substantially in the post-PPS period. Their main complaint is that with the very short hospital lengths of stay, there simply isn't time to do very much planning before the patient leaves the hospital, and the PHC provider often receives a patient without knowing what to expect. The hospital does get the patient discharged sooner, but the PHC provider is less prepared for meeting the patient's needs.

6.1 Hospital Discharge Planning

Clearly great emphasis is now placed on discharge planning in Portland. In many hospitals, a finance department representative is involved early in discharge planning, as well as the traditional UR nurses and social workers. Most hospitals use various "flags" to identify patients, and rely on physician referral as well. Some discharge planners make rounds themselves, looking for patients who will require discharge planning; they do not wait for physician referral. The "flags" generally include: age over 65 or over 70, all hip patients, all stroke patients, patients living alone, a history of hospital readmissions, etc. Any patients identified in this manner are assessed for discharge planning needs. Discharge planning begins much earlier in the hospitalization than was true in the past; in some hospitals it begins at or before admission.

Some hospitals now have HHA planners working in the hospital, particularly if the HHA is owned by the hospital. In one instance, the former VNA nurses who did discharge planning in the hospital were hired as hospital staff, to promote effective discharge planning. Many hospitals still use social workers for discharge planning, but have supplemented them with utilization review staff or business staff. Virtually all hospitals have increased the discharge planning staffs.

A few discharge planners express the opinion that readmissions, particularly for frail elderly patients, could be reduced if these patients were not discharged so early after their first admission. The planners feel early discharge may be more expensive for some patients in the long run, in a total care sense if not in a per admission sense (PPS emphasizes costs per admission). Discharge planners also mention that patient education needs are a concern when discharging patients earlier. In addition, they are concerned about a perceived lack of Medicare coverage for necessary post-hospital services; they feel responsible for patients who are discharged early and do not receive services due to lack of coverage.

Physicians seem to be somewhat more involved in discharge planning now, and most say they feel discharge planning is much improved. Some discharge planners, however, complain that physicians do not understand PPS, do not refer patients to discharge planning in a timely fashion, and may misinform their patients by telling them their "DRG days are up." Other discharge planners describe a system in which physicians are the overall case managers and work very closely with the utilization review department and discharge planners.

The extensive networking in Portland is quite useful for discharge planning purposes. Networking makes arranging for HHA services relatively simple, and facilitates nursing home placement as well. Some HHAs have added services not covered by Medicare, such as private duty nurses and homemakers, which may be necessary to facilitate early discharge.

6.2 Home Health Agencies

HHAs are rapidly affiliating with vertically-integrated networks. There has been some growth in the HHA industry in recent years, as some hospitals have moved to start their own HHAs. Many of the free-standing HHAs and the Visiting Nurse Association have become affiliated with a particular hospital or group of hospitals, and some free-standing HHAs have closed. There is apparently only one truly free-standing HHA left in the greater Portland area; it does not provide a great deal of post-hospital care and is thus not in direct competition with the hospital-affiliated HHAs. Nursing homes tend to have agreements with a number of hospitals at the same time. HHAs are more likely to "belong" to one primary hospital or group of hospitals. As a result, HHAs are in less direct competition with one another, once they affiliate with a network.

The fact that many hospitals have purchased or developed their own HHAs, is advantageous for both parties. The HHA receives services such as accounting, supplies, personnel, etc. from the hospital at a much lower cost than if it was freestanding, while the hospitals have a ready capacity for safely discharging patients earlier from the hospital. The largest HMO operates its own HHA as well. The HMO prefers to keep patients with the potential to be extremely costly within its own system. Any excess demand is met by contracting for services with the freestanding HHA. This is similar to the HMO's policy to keep maternity patients within the HMO hospital, while excess ICU patients are placed in another hospital; ICU patients have fairly predictable costs per day, while OB patients' utilization must be carefully monitored.

HHAs have hired new staff and retrained existing staff to provide the high-tech services many patients now require. HHAs care for more patients needing tube feedings, oxygen therapy, IV antibiotics, etc. They do more patient education than in the past and feel this service should be reimbursed by Medicare, because it no longer occurs in the hospital. Patients are discharged earlier by all reports, but this is not necessarily bad; some HHA administrators feel that it makes the nurses' work more challenging and interesting.

Most of the problems HHAs describe have to do with Medicare coverage of particular services, and FI interpretations of coverage restrictions. One interviewee states that "anything involving the laying on of hands and manipulation, we know will be covered" but many other things she feels should be covered, are not. One clear example is administering an enema (not covered) vs. digital stool extraction (covered service). Respondents also feel that the FI is very strict about skilled assessment visits. HHA nurses feel that good patient care includes nursing assessments, but the FI usually will not cover this, just as they do not cover patient education visits, which the nurses also feel are essential to good patient care. HHAs also have problems with FI definitions of homebound, daily care, and intermittent care. For example, a minimum of three visits are required for intermittent care to be covered. Even when one or two visits would do, nurses must justify providing three.

In general, the Oregon FI is reported to be strict but approachable and understandable. Administrators in HHAs have been able to learn the "rules of the game" and the FI is reasonable about working out problems. The single greatest concern expressed by industry respondents involves the switch to the regional fiscal intermediary in California. Apparently, HHAs in California have a strong dislike for that FI; some Oregon HHAs have joined the California HHA association have learned about this long-standing animosity, and are apprehensive about the coming changes.

Among the problems home health administrators anticipate with the California FI are such things as automatic denial if all information is not complete and correct when a claim is first submitted, i.e. no opportunity for the HHA to provide additional data; long delays in payment; no new staff hired at the FI in preparation for the addition of Oregon HHAs; and poor communication with providers. The FI has told HHAs to expect long delays (up to 120 days) before any payments are made from the California FI. The switch will therefore cause cash flow problems for many HHAs.

The California FI has held workshops instructing HHAs about the things they must never write on a claim. Automatic denials will occur if HHAs mention: teaching, family caregivers, social reasons for a visit, chronicity of medical problems, etc. The HHAs will continue to provide teaching services, chronic care services, family caregiver respite services, etc. but probably will not submit claims for fear of denial increases. Administrators say they will silently absorb the costs of providing these services that they feel are essential for good patient care.

Another problem mentioned in several HHAs and nursing homes is that of tremendous increases in their liability insurance, particularly in 1986. Insurers are apparently concerned that earlier hospital discharge will result in increased risk for PHC providers, and have therefore raised rates. One nursing home reportedly had no increase at all in insurance claims filed, but their annual premium increased over 300%. An HHA respondent describes a similar large increase, based on the insurer's perception of risk, rather than any actual experience justifying premium increases.

6.3 Nursing Homes

There appears to be no serious shortage of skilled nursing beds in Portland. As is true in other communities, however, the most desirable and reputable nursing homes have fewer beds available for post-hospital patients on a quick turn-around, because their occupancy rates are very high.

Medicare is a fairly small part of nursing home business. Although there have been changes and problems related to PPS, the fact that it is a small part of their business means that nursing homes do not feel a pressing need to change their practices dramatically. Most nursing homes have agreements of one sort or another with hospitals in town, and have a place in the networking that is so pervasive in Portland.

Caseload severity is greater, mainly due to the move to home care for many patients who might previously have spent a week or two in a SNF

bed. The increase in severity seems to have leveled off, however. The dramatic increase seen in 1985 may have reflected an adjustment for underprovision of services in 1984. Patients are discharged earlier and need more high-tech services in the PHC setting, and nursing homes have had some trouble recruiting qualified staff to provide these services. Several nursing home respondents report more deaths occurring soon after admission than was true in the past.

Hospital discharge planning is much improved, although nursing homes are less likely to have staff members doing discharge planning in the hospital than are the HHAs. Screening patients for admission to the nursing home has become essential, because hospitals are in such a hurry to discharge that the nursing homes are often not well-informed about the particular needs of a patient, eligibility, dual coverage, etc. Nursing homes are concentrating on this initial screening effort for their own self-protection. Friday afternoon discharges have reportedly increased, with little advanced planning for high-tech patients' needs. At least one nursing home has promulgated a policy of taking no new admissions between 12:00 p.m. Friday and Monday morning.

Problems related to the FI include slow payment, disagreements over the need for rehabilitation services, and strict definitions of skilled care needs. At the same time PPS was initiated, the FI tightened up and at least one nursing home reports that there are patients who would have been approved for SNF care in the past, but are not approved today.

Nursing homes also have experienced tremendous increases in liability insurance, probably for the same reasons as HHAs. Since per diem payments are determined based on past costs and premium increases are current costs, Medicare calculations do not capture this increase for at least one year. Other per diem third party payers do not either. This is one of the many reasons that the nursing home per diem payment is a problem in a time of rapid change.

7.0 PPS PROGRAM OPERATIONS

7.1 Peer Review Organization

The PRO, Oregon Medical Peer Review Organization (OMPRO), was formerly the PSRO for the Portland area and has a large private sector involvement, focusing on providing technical assistance to health care providers. This work includes case management and concurrent review for long term care providers; and consulting services in long term care management, medical records review, and use of patient care plans. This PRO also has the Medicaid contract for the state.

Virtually all Medicare reviews are conducted on-site, except in a handful of hospitals where less than 10 records per month are photocopied and mailed to the PRO. This adds to the generally good working relationships with providers; communication with providers is considered good, both by the PRO and by providers.

7.1.1 SuperPRO Ratings and HCFA Contracting

The SuperPRO ratings for this PRO are better than average for quality reviews and medical necessity, and about average on admission referral reviews and DRG validation. The objectives specified in the first contract yielded very few denials, indicating that either the objectives were poorly specified or that they did not focus on the relevant issues for admissions and quality of care. PRO interviewees are of the opinion that the latter is the case; many of the objectives they originally proposed, which they felt were better, were rejected by HCFA. Their plan for DRG validation, for example, was rejected and they had to invest $100,000 more than they had planned for the DRG effort. Now in the second round of contracts, the national scope of work describes precisely the plan this PRO originally suggested.

In the recent contract negotiation, the PRO submitted a proposal well in advance of the deadline, but was not contacted by HCFA to begin negotiations until the current contract had expired. This meant the PRO had to stop performing Medicare reviews and lay off the staff devoted to the Medicare contract. After more than 6 weeks of negotiations the new contract was finally signed. This delay resulted in a 6 week backlog of claims. Many of the former staff were no longer available and new staff had to be trained for over 2 months to reach the proficiency level of the former staff. This was all extremely expensive for the PRO and HCFA did not absorb any of the additional costs incurred.

This PRO is very concerned about HCFA's emphasis on denials in the contract renewal process. Respondents feel that the good SuperPRO review was essentially ignored, in favor of denial rates. They feel that because utilization review is so advanced in Oregon, due to many years of required second opinions, strict UR, etc., there is little left to cut in

the system here. A state that had little or no PSRO activity (e.g. Texas) can be expected to have high denial rates when UR is begun. In Oregon, the PRO feels that current low rates of denials indicate that providers are operating within fairly strict guidelines already.

7.1.2 Research and Development

OMPRO recently completed a HCFA study on appropriateness of discharges, for which Oregon was one of several pilot sites. The study was reportedly quite successful in developing an instrument to measure patient dependency at discharge, and respondents are disappointed that there was no sharing of results with the other study sites.

In addition to such research studies, the R & D Department is responsible for developing contract objectives for the Medicare contract. One of the new quality-related objectives is of concern to them. All PRO contracts now require that a pure 3% random sample of all cases be reviewed using the generic quality screens and that focused reviews for each screen, in each hospital, be developed. In Oregon, this sampling will yield approximately .3 cases for each quality screen, in each hospital, per quarter, according to the Director of R & D (3% equals 125 cases per quarter in 75 hospitals in the state, divided by 6 generic quality screens, yields .3 cases per screen, per hospital, per quarter). The sample is too small to develop the focused reviews.

The generic quality screens require that at least 30% of all cases identified by the screens be referred to physicians for review. This PRO has already found that the great majority of cases flagged by these HCFA-mandated screens are problems of documentation, not quality of care. Only 8% of identified cases prove to involve real quality questions, yet the PRO must pay for 30% physician review. Although the concept of nationally standardized quality screens is probably a good one, OMPRO staff point out that the current generic quality screens were developed from studies focusing on malpractice issues, and the types of documentation necessary to avoid malpractice problems. This PRO feels that PRO input (which was not solicited) in formulating quality screens would have produced items that more clearly identify true quality of care problems.

OMPRO staff feel that one of the original purposes of the PSRO program was to develop new technologies for utilization review, at which venture the PSROs were very successful. Interviewees feel that such investment in UR research is no longer a HCFA priority, and the research role has disappeared, to be replaced by "police tactic enforcement" of regulations.

7.1.3 Quality Assurance and Record Reviews:

The first PRO level of quality review is conducted by RNs using a profiling system, and any problems are referred to physicians. This second level consists of a panel of 100+ specialists, who review the quality of care and estimate the severity of illness. If any problem is

identified, the attending physician is contacted. If no resolution is reached, the last level of review includes three physicians who present each case to the quality assurance committee of the PRO. The QA committee has seven members, one from the state, one from rural Oregon, and five from the Portland area. The three medical advisors make the final determinations, with the guidance of the committee. Approximately 15 percent of all cases the nurses initially refer for consideration go to the level of the QA committee. This system is similar to that of other PROs.

The single largest group of denials is generated by preadmission review. Here the procedure yielding the most denials is laminectomy. Preadmission review and second opinions for surgery have strictly controlled utilization and the PRO staff is concerned about enforcing even more stringent HCFA contract requirements. They feel there is a liability issue involved. For example, if patient care is delayed or procedures are not performed and patients suffer medically, the PRO as well as the provider may be held responsible. OMPRO would prefer to emphasize prepayment review rather than stricter preadmission review for two reasons: 1) previous preadmission review has already had the desired sentinel effect of preventing unnecessary procedures, and 2) patients will not suffer medically under prepayment review, although they (and their providers) may suffer financially if a procedure is denied.

The pattern observed by this OMPRO is that when a new guideline is implemented, some denial activity occurs, but that as providers come to understand what is required, denials decline. For example, the new concern over planned readmissions will probably lead to some denial activity in the beginning. However, hospitals already seem to be taking the approach of simply not submitting a bill for the first "diagnostic" admission, preferring to bill for the more costly "procedure" admission. They are not able to combine both admissions very often, because this is simply contrary to established medical practice. When hospitals cannot change physician behavior, they simply absorb the costs HCFA has decided not to reimburse. This does not save money in terms of total expenditures for health care, but it does shift more of the burden to providers and beneficiaries.

7.2 Fiscal Intermediary

Blue Cross of Oregon recently became the FI for Idaho as well as Oregon, and will process all Part A Medicare Claims for both states. At the same time, it lost the contract for processing home health agency Medicare claims to the new regional home health FI in California. Of the 60 HHAs in Oregon, approximately 25 will switch to the regional FI this fiscal year; the provider-based HHAs will reportedly not switch for some time.

This FI has a system of electronic data processing for filing claims. Although a few other states have such systems, this FI reports that only one or two other systems are as extensive and well-accepted by providers. Fully 85 percent of all claims are entered electronically by

providers, with all edits done during data entry. For example, edits for consistency between patient age and DRG are performed before the claim is permitted to enter the FI system. If information is incomplete or incorrect, the claim does not enter the system; the provider knows immediately that something is wrong. This avoids delays from sending claims back to providers for further data. Claims entered electronically are processed and paid three times per week; those entered manually, only once a week. The convenience of knowing immediately when data are insufficient, coupled with faster payment, has resulted in overwhelming acceptance of this system among providers.

When PPS began, the FI did very little provider education, other than workshops on MCRs and new billing practices, and did not see this as its responsibility. The AHA, OHA, and HCFMA, did a great deal of education. The FI does notify providers of changes in regulations, via bulletins.

In general, hospitals in Oregon do well under PPS. The Pacific region contains California which has one of the highest state average costs in the country and four very rural states. This brings all the rural states' rates up a good deal, while lowering California's. Packwood's amendment helped most hospitals in the state, with the exception of some urban hospitals which essentially break even on the trade off of hospital specific and fully federal rates.

PPS is not viewed by this FI as being the issue of greatest importance in the Portland area. Rather, the intense competition and networking is of paramount importance in shaping the structure and delivery of health services. There are probably too many HHAs and certainly too many HMOs at this time, and the FI predicts that several HHAs will close or consolidate and at least a few of the HMOs will not survive.

7.2.1 PIP and CPEP

Of the 220 providers this FI oversees, only 30 are on PIP, two of which are HHAs. Most providers prefer the speed of electronic claims entry to the paperwork involved in PIP. When instructions were received from HCFA to slow down bill processing, this FI saw no reasonable way to slow down their on-line electronic data entry system. Since their funds were adequate to continue processing on their fast schedule, they just proceeded.

The biggest problem this FI has with its CPEP score is the requirement to save $5.00 for every $1.00 spent on administration. The area where there is hope for saving a lot of money is inpatient review, but now the PROs perform all those reviews. The FI never really achieves the 5 for 1 standard. The FI Director is of the opinion that HCFA did not require the 5 for 1, Congress somehow decided that this level was appropriate and mandated it legislatively.

7.2.2 SNFs and HHAs

Approximately 47 percent of SNF and HHA claims are currently reviewed. SNFs have the highest rate of denials for technical reasons,

usually due to poorly trained SNF staff who do not understand the data requirements of the FI. Generally providers using electronic data entry have fewer technical denials, because technical errors prevent their claims from ever entering the system for review.

Patients are clearly being discharged earlier than in the past and needing more intensive, high-tech services, and this is not necessarily inappropriate in terms of patient case management. SNFs may be the most seriously hurt by earlier discharges from hospitals. HHAs are paid for the services they render but SNFs are paid a per diem, and that per diem is calculated based on MCRs that are over a year old. If new services must be provided due to increased patient severity at discharge, the HHA simply provides those new services and bills Medicare for covered services. But the SNFs must live within their per diems, while somehow absorbing the costs of the new services required by patients who are discharged earlier than in the past. Only at the end of the year when the per diem is recalculated is there an opportunity to increase the per diem, but this is not retroactive. Medicare's new PPS is the culprit behind the rising costs for providing care to Medicare patients in SNFs. This FI predicts that some SNFs will simply stop serving Medicare patients, eliminating an essential component of aftercare, and forcing some patients to remain hospitalized longer for lack of a SNF placement.

7.2.3 Record Review and Definitions of Services

There is a three-tier system of record review in place, similar to that used by other FIs. Semi-automated screens flag claims for review, then RNs review these cases and decide which to pay and which to refer for further review. The next level includes four medical advisors who consult with Blue Cross. The final decision is made by these medical advisors, who call in consultants when necessary. Beneficiaries can of course appeal determinations.

There are a number of definitional issues which arise as providers attempt to work within the FI's rules for reimbursement. In general, nursing homes and home health agencies understand these definitions fairly well, although they feel that some are inappropriate or may result in diminished quality of care for Medicare patients. Among the definitions that are of concern among providers of post-hospital services are the following:

- Daily Care
- Intermittent Care
- Homebound Status
- SNF Rehabilitative Care
- Skilled Home Care Assessments

Daily care can be seven days per week for therapists, or intermittent skilled nursing care. Intermittent means less than seven days per week but more than once in 60-90 days. There is no limit on the number of weeks of intermittent care.

The definition of homebound is problematic for the HHAs and the FI. The HCFA regional office did an audit with their own nurses and seemed to indicate that homebound means bedbound. Other regional offices across the country have differing definitions. This FI denies very little homebound care, because of this confusion and because the HHAs have reportedly learned what they must write on the claim to justify the homebound status.

A significant problem for SNFs is the definition of rehabilitation care. Rehabilitation must be daily care which can only be rendered in an inpatient setting. Deciding whether care could possibly have been rendered at home is difficult. The deciding factor is often one of physician practice preferences. Consider, for example, two identical hip-replacement patients; one physician says to begin walking in two weeks, while the other forbids weight-bearing for 6-8 weeks. The first patient might manage with adequate home care, while the latter would to to a SNF. Again, since the decision is difficult and physicians vary, the FI prefers to err on the side of the patient by covering SNF rehabilitative care when a case is questionable.

The issue of paying for skilled assessments is another difficult one for HHAs. Assessment is a skilled service and is covered. The question is when are assessments necessary. Assessments that are done "just in case" because a semi-senile patient might not know when to call a physician, are considered preventative and are not covered. Assessments that are done to judge the need for the current or future care plan, recommend readmission to a hospital, etc. are deemed necessary and are covered.

Many of these definitional issues will be of less importance for this FI as home health agencies switch to the regional FI in California. In general, these problems are not caused by poor communication between providers and the FI, but have more to do with disagreements over interpretations. In general, providers report good working relationships with this FI, and the FI does not perceive any significant problems either, other than the concerns mentioned above.

There is one significant inequity in the HHA benefit, which this FI expressed. Patients who formerly had to spend six weeks hospitalized for IV antibiotics, could now go home due to improvements in technology, if outpatient drugs were a covered benefit (they are not). Chemotherapeutic agents administered via an infusion pump are covered, however, since they are considered a supply for the medical equipment (pump). Physicians must either keep the antibiotic-dependent patient in the hospital or order home infusion pumps, which are not really necessary for antibiotic patients, but which make the drugs themselves a covered expense. This type of seemingly arbitrary coverage determination confuses physicians and can lead to unnecessarily antagonistic interactions between providers and the FI.

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